# U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

# BUREAU FOR GLOBAL HEALTH

# FY 2002 ANNUAL REPORT
# PARTS III - VI

## JUNE 2002

The attached results information is from the FY 2002 Annual Report for the Bureau for Global Health and was assembled and analyzed by USAID/GH.

The Annual Report is a "pre-decisional" USAID document and does not reflect results of USAID budgetary reviews. Additional information on the attached can be obtained from Richard Whitaker, GH/OFPS.

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Arlington, VA 22209-2111
Telephone: (704) 351-4006 ext.106
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# Bureau for Global Health (GH)
# FY 2002 Annual Report: Parts III - VI

## Introduction

USAID is a recognized world leader in global health, including family planning, maternal health/child survival, HIV/AIDS, and infectious diseases. The Bureau for Global Health (GH) portfolio provides strong technical support to field missions, highlights state-of-the-art programming, and maintains leadership status at both national and international levels. Specifically, GH defines its role as follows:

- **Technical Support to the Field:** GH is field-driven and provides requested technical expertise, information, commodities and services. GH constantly works with missions to assure an appropriate fit with country-specific situations. GH provides ready mechanisms that missions can tap for experience and knowledge that USAID has gained worldwide.

- **Research and Evaluation:** GH develops, tests, and disseminates new technologies and methodologies that contribute to successful field program implementation. A pioneer in results monitoring, GH collects and analyzes data to improve program performance and to assess impact. GH has led the work in the development of tools for program evaluation and trends analysis in the PHN sector.

- **Global Leadership:** GH's global leadership focuses on technical innovation, policy dialogue and resource mobilization. GH contributes to field programming by influencing the wider global community of countries, donors, foundations and non-governmental organizations. GH technical strength is derived from its multidisciplinary teams and strong partnerships with missions and cooperating agencies. These skills and relationships enable GH to maintain effective collaboration with a broad range of development partners in both the public and private sectors.

GH has built its portfolio on the dynamic synergies of these three program elements and continues to evolve its program to meet changing public health needs and field realities. It has very mature programs in family planning and child survival. These programs have successful on-the-ground experience and have capacities relevant to needs in the newer health areas, have received extensive field support to expand activities and have adapted activities accordingly. Newer programs, such as those addressing HIV/AIDS, are providing a rapid response to the pandemic. New maternal health and reproductive health interventions address persistent high maternal mortality rates. Tuberculosis and malaria programs combat newly re-emerging diseases. Through this program evolution, USAID has sought technical excellence and to have its programs grounded by field need. Illustrative examples of GH's comparative advantage follow:

**GH has technically competent staff available to the Agency at all levels**. Currently, GH has 72 direct hire and 110 non-direct hire technical and program experts who: manage a wide spectrum of diverse technical projects; provide technical assistance to missions in strategic planning, program implementation and evaluation; nurture and galvanize stronger partnerships with donors, foundations, and the broader PHN and development community; and garner support for our programs with stakeholders including the US public and Congress. GH technical strength is derived from its committed and competent people.

**GH is field-driven and field-centered.** Current staff are dedicated to coordinating PHN support to field missions through 62 country teams. In FY 2001, staff made over 164 trips (most of which were co-funded by the missions) to support mission and country programs. 63 missions/regional offices sent a total of $379 million in field support to be programmed through GH mechanisms.

**GH can quickly deploy top quality expertise** for strategic planning, program design and assessments, such as recently conducted in Uganda, Cambodia and Nigeria strategic exercises, or with the deployment

of a senior official to represent the USG and work with the conceptualization and development of the Global Fund to Fight AIDS, TB and Malaria.

**GH programs are flexible and can respond rapidly to field needs,** such as to provide rapid start-up, bridging and close-out for bilateral programs, or emergency needs such as with Hurricane Mitch and earthquake response.

**GH offers the field economies of scale** through central mechanisms, such as contraceptive procurement and logistics management, Demographic and Health Surveys and other rapid program assessment mechanisms.

**GH develops new, cost-effective, field based technologies** such as rapid and simple HIV/STD diagnostics, new and improved contraceptive methods, vaccine vial monitor technology, and the use of vitamin A to enhance child and maternal survival, and new approaches for addressing mother-to-child transmission of HIV/AIDS.

**GH influences the worldwide PHN agenda, develops world-wide standards and mobilizes resources for sector programs.** For example, GH shaped the development of the Global Fund to Fight AIDS, TB and Malaria; influenced the global health agenda through the Child Summit; developed monitoring and evaluation standards for HIV/AID program assessments, and developed the Global Alliance for Increased Nutrition, a new public-private partnership to address malnutrition.

**GH effectively responds to over $150 million in Congressional directives**, not efficient or feasible for mission programming, such as: the UNAIDS contribution, the polio eradication partnership, micro-nutrient alliances, Global Alliance for Vaccines and Immunization, displaced children and orphans, war victims fund, and microbicide research and HIV/AIDS vaccine research.

**Annual Report III: FY 2001 Performance Narrative**

**Program Performance**

**SO1 - Increased use by women and men of voluntary practices that reduce fertility**

USAID has been a world leader in supporting voluntary family planning programs in developing countries for over 35 years, helping families all over the world achieve their desired family size. USAID programs have had a significant impact, contributing to a decrease in average number of children per family in developing countries (excluding China) from more than 6 in the 1960s to the current level of less than 3.6 in 2001. Furthermore, by helping women have only the children they want and helping them space their children at least two years apart, family planning can prevent 25% of maternal deaths and 25% of infant deaths. The Bureau for Global Health (GH) has played a critical role in this progress through its field-driven program design, provision of comprehensive technical support, timely and authoritative research, global leadership, and high-impact partnerships.

The modern contraceptive prevalence rate (CPR) among married and unmarried women--the indicators GH uses to measure progress at the SO level--continue to show impressive gains. CPR among married women (Indicator 1.0.1) increased to almost 42%, and among unmarried, sexually active women (Indicator 1.0.2) to almost 53%. In contraceptive research, 27 leads are under development, four leads advanced to the next stage, and a new non-latex male condom was approved by the Food and Drug Administration (Indicator 1.1.1). On average, women of reproductive age know of 6.5 methods of modern contraception (Indicator 1.4.2). With the SO meeting its targets, key achievements of the program during this reporting period include:

- The safety of six microbicide compounds was demonstrated in initial clinical trials.

- The reliability of a model predicting willingness-to-pay for contraceptive services was confirmed, thus eliminating the need for case-by-case willingness-to-pay studies.

- Studies of alternative methods of collecting data on socio-economic status established that a measure based on household assets was as accurate and less expensive than collecting expenditure data.

- The Kenyan government signed an agreement with the World Bank to use $10 million in loan funds to purchase condoms, a decision based in part on a GH-funded analysis of condom needs in Kenya for the 2001-2004 period.

- In Ghana, the number of midwives diagnosing and treating sexually transmitted infections and providing emergency contraception and post-abortion care services to adolescents increased after they were trained to provide reproductive health services to adolescents.

- An on-the-job training program in Zambia resulted in 5,500 clients receiving comprehensive post-abortion care and family planning services in one year alone.

- Partnerships with the commercial sector resulted in the provision of contraceptive protection to an estimated three million couples.

- Advocacy efforts through PVOs helped to reduce female genital cutting in Egypt and Nigeria.

The ultimate beneficiaries of these investments are the women and men, including adolescents, who are able to make more informed decisions about their reproductive health and childbearing and who have access to a broader range of contraceptive options. Other beneficiaries include service providers whose skills and knowledge are increased, governments that are able to target their resources more effectively

and efficiently, and private sector entities (for profit and not-for-profit) that are better able to design, implement, finance, and evaluate sustainable family planning/reproductive health (FP/RH) programs.

Of course, challenges remain. GH used its results review and annual budget processes as opportunities to bring key programmatic issues to the attention of Bureau senior staff and then to allocate staff time and resources towards addressing them. In FY 2001, youth and the HIV/AIDS crisis were identified as particular areas that required attention. Over one billion young people still have inadequate access to FP/RH information and services that can help them delay sexual initiation, postpone childbearing, and protect themselves from sexually transmitted infections, including HIV. GH launched a five-year initiative specifically focused on the RH needs of young people in FY 2001. In addition, GH has identified a staff person who is spearheading efforts to ensure that the Bureau's approach is strategic and responsive to field needs. A second challenge facing SO1 is to ensure that FP/RH remain high on the policy and programmatic agenda in countries significantly impacted by HIV/AIDS. To this end, a Family Planning-HIV Integration Working Group was established to identify opportunities and recommend approaches for addressing FP and HIV prevention needs in synergistic ways. The reorganization of the G/PHN Center into the Bureau for Global Health provides a welcome opportunity to address these two issues, and others that are intra-sectoral in nature, in a more comprehensive and holistic manner.

**SO2 - Increased use of key maternal health and nutrition interventions**

Each year more than 500,000 women die in childbirth and millions more suffer long term disability, most of which is preventable. USAID focuses on improving maternal nutritional status, improving preparation for birth, promoting safe and clean delivery, improving postpartum care and treating obstetrical complications.

Evidence is now available that long-standing investments are starting to make national level impact in maternal mortality reduction in USAID-assisted countries. Egypt has registered a dramatic decline of 52% in maternal mortality over an 8-year period (1992-2000) and Indonesia has documented a 14% decline over a three-year period (1994-1997). Political commitment by the governments, investment by a variety of partners, and USAID technical assistance contributed to this success. At the SO level, significant country level achievements have been realized in use of key services. Where DHS has been conducted more than once in the past decade, increases of 26%-50% in skilled attendance at delivery have been documented in Egypt, Yemen, Niger, Morocco, Mali, Nigeria, Bolivia, and Uttar Pradesh, India.

Research and Evaluation:

- In 2001, a maternal health research agenda was developed and new research studies have been initiated, including the feasibility of providing effective antenatal care in resource-poor settings, the actual skill level of credentialed birth attendants, a new approach to management of postpartum bleeding, reduction of hospital delays for life-threatening complications, identification of the elements of the “enabling environment” for skilled birth attendants, and the causes of maternal mortality with special attention to the contribution of malaria and HIV.
- In an innovative prepayment program for maternal and newborn health services, utilization increased by 50% for health center deliveries and 25% for prenatal services in two pilot areas in Rwanda.

Policy and Advocacy:

- Publication and dissemination of Managing Complications in Pregnancy and Childbirth is filling the need for evidence-based information on state-of-the-art obstetric practices. In collaboration with the WHO, UNFPA, UNICEF and the World Bank, these guidelines have been translated into French, Spanish, Russia, Mandarin Chinese, Mongolian, bahasa Indonesia, and Laotian and are being adapted in regions and countries of the world.
- In Ukraine, based on a review of the scientific evidence, national policy guidance was revised to reduce the number of routine antenatal care visits and ultrasounds in pregnancy, resulting in projected substantial financial and human resource savings.
- To address the problems of anemia and low birth weight from malaria in Tanzania, chloraquine prophylaxis of pregnant women was replaced by the more effective intermittent treatment with sulfadoxine-pyrimethamine (SP). Additionally, USAID has assisted Tanzania to forecast SP

requirements and revise maternal and child health cards for monitoring malaria treatment in pregnancy.

Community Mobilization:

- Over the past two and one-half years, the White Ribbon Campaign for Safe Motherhood, an international coalition to promote increased awareness of the need to make pregnancy and childbirth safe, now has members in 20 countries with newly established secretariats in Vietnam and Malawi.
- In Nepal, a Birth Preparedness package has been developed for use by female community health workers to facilitate communication between women, their families and their communities to promote planning for birth and problem-solving in the event of an emergency.
- This past year, the first-ever government permitted march on the Taj Mahal was a landmark event that heightened awareness of maternal mortality in India, where a quarter of the world's maternal deaths occur.

Maternal Health Services:

- To develop a sustainable capacity to meet regional needs for expert trainers and leaders in maternal and neonatal health, the Regional Expert Development Initiative has been launched. Selected individuals from Asia, Latin America and Africa have been updated in clinical skills, provided experience in competency-based training, and supported in taking on leadership functions in the past year and are now available to provide maternal and neonatal health expertise in their countries and regions.
- Pregnancy-induced hypertension (PIH) was the leading cause of maternal mortality in Tver district, Russia. With the introduction of evidence-based guidelines to use the drug therapy of choice, magnesium sulfate, there have been no convulsions or maternal deaths.
- Introduction of evidence about episiotomy and treatment of bleeding has led to new practices in Amatitlan Hospital in Guatemala that has over 4,000 births annually. By instituting low cost, effective procedures, the number of blood transfusions and unnecessary episiotomies has decreased, resulting in reduced costs for transfusion equipment, sutures, anesthetic, sterilization and laundry.

Severely limited resources in contrast to the extent of the problem and the fact that solutions are imbedded in strengthening the health care system as a whole present the biggest challenges for this SO. Attention to infectious diseases draws not only manpower, but also resources, thus adversely affecting maternal and child health programs. Advocacy and awareness raising at all levels remain very important. Multiple opportunities to partner with others bring new possibilities, but also run the risk of draining limited resources as we search for common ground and seek economies and greater effectiveness in coordination efforts. While we have good evidence about technical interventions, we have less evidence about approaches and strategies that work for resource-poor environments and this will be an area where we will invest more heavily in order to inform programming choices in the future.

Primary beneficiaries are pregnant and postpartum women and their infants. Secondary beneficiaries are the women's families, including other children, and their communities.

This SO has met its SO level target this past year, with the self-assessment of "meeting targets." The percentage of births attended by medically trained personnel of 49.9% surpassed the target of 48.9%. There are regional differences. In the ANE, E&E and LAC regions, progress is slightly ahead of the target. In Africa, there is a slight increase recorded, but not at the target rate of 1% per year. To address this issue, we are attempting, insofar as GH can, to have global projects address the unique problems within Africa. In previous years we have reported on the number of maternal health research studies planned, ongoing and ready for dissemination but we have not found this indicator useful for assessing the quality of our work and have decided to eliminate it. The Maternal and Neonatal Program Index (MNPI) is gathered every three years and will be reported in 2003.

Performance considerations related to resource recommendations: The S02 team has used results in a recent Maternal Health Program Review. The SO will place special emphasis on the problems in sub-Saharan Africa and consolidate activities to achieve improved results. In recognition that resources are

limited, we are putting additional emphasis on research and documenting results in order to inform programming to achieve progress.

**SO3 – Increased use of key child health and nutrition interventions**

Although the U.N. Special Session on Children - scheduled for September 19-21, 2001 - was postponed, the associated global analysis of the decade's progress in child survival, health and nutrition confirmed USAID's analyses of previous years. This global analysis showed that significant, measurable progress has been made in key child health and nutrition outcomes. Progress was especially notable in the use of Oral Rehydration Therapy (ORT) to save the lives of children with dehydrating diarrheal illness: UNICEF estimates that, largely because of use of this therapy (developed with substantial U.S. support), the global goal of 50% reduction in child deaths from diarrhea was met by 2000. In USAID-assisted countries, progress in immunization continued, with DHS data showing 42% of children fully immunized by their first birthday. Polio eradication continued to progress, with under 3,000 cases reported in 2001 and evidence that one of the three strains of polio virus may have been eradicated. Breastfeeding rates increased in USAID-assisted countries, boosted by demonstration of effective programmatic approaches (see below). Through the global Vitamin A Alliance, with USAID as a leading partner, over 100 million vitamin A capsules reached young children in 2001; based on data from Vietnam and the Philippines, this effort is projected to be saving over 250,000 children's lives each year. Still, significant challenges remain: many countries in southern Asia and sub-Saharan Africa fell far short of the goals set for the decade. Progress in children's survival and health was limited or non-existent in some countries where USAID has not been able to work in recent years – including Pakistan and Afghanistan. Treatment of children with pneumonia has not progressed, reflecting the weakness of health care services in poor countries. In many countries, further progress in child survival will require dealing with the high rates of mortality among newborn infants. In almost all countries, further improvement in child survival will require identifying and reaching children not yet being reached. These children – often affected by poverty and social disempowerment – bear a disproportionate part of the remaining burden of illness, malnutrition, and mortality. Reaching them will need to be a major focus of this decade.

During this period, in which the SO met its targets, there have been significant achievements in each of SO3's technical areas:

- In immunization, the Bureau's "Boost Immunization" initiative was expanded to 14 countries; in five countries where the initiative began, coverage in 2001 increased by 5% on average. GH also provided technical assistance in immunization to additional key countries including India, Nigeria, and the Democratic Republic of Congo. In DR Congo, GH's work contributed to reaching almost 40% coverage for DPT3 and measles in 2001, up from about 15% three years earlier. Through its work with the Global Alliance for Vaccines and Immunization (GAVI), GH leveraged the substantial U.S. contribution to the Children's Vaccine Fund: as the only donor country representative on the GAVI review panel, GH helped assure the quality of over 50 country proposals that will direct the investment of over $800 million by 2005. GH also worked with WHO and UNICEF to develop a shared strategy for accelerated control of measles. In Polio Eradication, GH focused on improving the quality of National Immunization Days (NIDs) and in increasing NID coverage through communication and social mobilization, so that the investments in NIDs achieve maximum impact.

- In prevention and treatment of diarrheal diseases and respiratory infections, USAID has supported the WHO/UNICEF "Integrated Management of Childhood Illness" (IMCI) initiative; this initiative is now being implemented in over 80 countries. During 2001, a joint USAID/DfID/WHO/UNICEF evaluation of IMCI concluded that in high mortality countries, IMCI must address critical constraints to child health services – especially drug availability – and reach children beyond the limited reach of public health services. In response, GH expanded its "Drug Management of Child Illness" initiative, developed in the Americas, into East Africa, four Francophone African countries, and Haiti. GH also intensified collaboration with U.S. PVOs and international partners in implementing a "community component" of IMCI; with USAID support, the PVO CORE Group developed a program framework for this community component that has been endorsed as a major child survival strategy by 13 U.S. PVOs including World Vision, Freedom from Hunger, Catholic Relief Services, and Save the Children.

This "community component" of IMCI is now being implemented in over 40 countries. GH also continued support for other approaches to preventing pneumonia and diarrhea, including field testing of a pneumonia vaccine in the Gambia and evaluation of a new vaccine against rotavirus, a major infection causing dehydrating diarrhea. Evaluation of zinc treatment of diarrheal illness found significant reduction of severity of illness and a 50% reduction in mortality, leading to a WHO recommendation that zinc supplements be added to ORT in treatment for diarrheal illness.

- In nutrition, GH continued its leadership role in micronutrients, especially vitamin A capsule delivery through the global Vitamin A Alliance. New approaches were developed to deliver vitamin A independent of Polio NIDs, using linkages to routine immunization and other services and "Child Health Weeks;" such approaches were undertaken in 20 countries, with 13 achieving national coverage. In micronutrient research, a study of vitamin A dosing of newborns showed significant reduction of mortality in the first six months of life. In Madagascar and Honduras, GH-assisted programs succeeded in essentially doubling breastfeeding rates with significant program coverage (3.2 million population in Madagascar, three-fourths of the total population in Honduras); earlier similar results in Ghana, Benin, and other sites indicate that these program approaches are ready for replication in additional countries.

- In the new area of newborn survival, GH collaborated with WHO to produce badly needed technical guidance for medical professionals in developing countries, provided technical assistance to 11 countries, and began field trials in India, Bangladesh, and Pakistan of interventions to reduce low birth weight and newborn mortality.

Among the major challenges to the SO3 team was the increased demand for effort in support of an increasing number of potentially high impact initiatives such as GAVI, Polio Eradication, the Vitamin A Alliance, accelerated measles control, "community IMCI," newborn health, and the U.N. Special Session on Children. Work on these initiatives did not decrease the ongoing work of managing existing programs and providing support to field missions, and was compounded by the effort required in reorganization. The team responded by making the most strategic allocations of effort possible, forming teams around each of these initiatives, and extra work by virtually all team members. The decline in resource levels for the core areas of child survival outside of micronutrients and polio was another challenge. The team consolidated and reduced the number of activities to focus available resources on highest impact areas, but some opportunities for greater impact in areas such as non-polio immunization, breastfeeding, and newborn health could not be pursued.

Beneficiaries of GH's efforts vary by the nature of the effort. For technical assistance to field programs, the beneficiaries are those of the catchment areas of the missions' programs (as with the 3.2 million subset of Madagascar's population reached by the nutrition program). For global leadership and research and development activities, the population reached may be greater. For example, USAID's leadership in the global vitamin A Alliance reached children in over 50 countries, and research on improved ORT, pneumonia and diarrhea vaccines, and micronutrients benefits children worldwide.

In regard to the effect of performance assessment on resource decisions, we utilized an SO-based process to develop our FY 2001 budget allocation. Each of the SO teams developed a budget submission based on assessment of performance, priorities for the coming year, and identification of the planned contribution of each activity to the SO's planned results. This budget was combined with a budget based on project requirements, developed by each division, to form the basis for a negotiated final budget that substantially favored the SO input.

**SO4 – Increased use of improved, effective and sustainable responses to reduce HIV transmission and to mitigate the impact of the HIV/AIDS pandemic**

In response to the expanding worldwide HIV/AIDS epidemic, at the Administrator's request, the Office of HIV/AIDS (OHA) took the lead in developing a more strategic approach to allocating HIV/AIDS resources, which has been vetted throughout the Agency. This new plan expands the number of priority countries from 17 to 23 and more than doubles the funds available for field programs. The Office played a crucial

role in fostering the development of the new Global Fund to Fight AIDS, Tuberculosis and Malaria by supporting secretariat operations and providing needed technical guidance. During the past year, the Office also took a lead role in the U.N. General Assembly Special Session on HIV/AIDS (first special session ever held on a health issue), where 160 nations committed to increased HIV/AIDS action.

USAID country missions and the Office are working in 46 countries and 9 regional programs around the world to achieve the following results:

- USAID has continued to work with other donors to keep HIV prevalence rates low (less than 2%) in Senegal, Philippines and Indonesia and is helping to reverse the epidemic in several higher prevalence countries (Uganda, Dominican Republic, Thailand, Zambia, Cambodia).

- The Office developed a monitoring and evaluation reporting system for all 23 priority countries, which will enable the Agency to collect and aggregate important data in a much more useful and timely way. In addition, we worked with UNAIDS and other donors to establish worldwide standardized HIV/AIDS indicators.

- Preventing HIV transmission from infected mothers to their children (MTCT) is urgently needed. An effective intervention exists, and USAID is testing it in low resource settings as well as developing tools and lessons learned so that this program can be made increasingly accessible. Currently, USAID is working to prevent MTCT in four countries and will expand to additional countries in 2002. In Kenya, IMPACT doubled the number of women with access to MTCT services (from 3,100 to 7,000).

- USAID presently supports 62 different projects to assist children affected by AIDS in 22 countries. During FY 2001, the Office mapped activities in each of these countries and developed a listserve of all implementing partners to communicate new approaches, tools and lessons learned.

- USAID funds 25 care and treatment projects in 14 countries. The IMPACT project is beginning work in Ghana on providing anti-retroviral drugs in collaboration with the Government of Ghana and UNICEF. Additional sites for the introduction of anti-retrovirals will be determined in 2002. These activities will provide important lessons on how best to deliver these life-prolonging drugs.

- Through OHA support, at least 1,145 Peace Corps volunteers and staff in 38 countries took part in 46 HIV/AIDS projects covering a wide range of activities.

- USAID is a founding member of the International HIV/AIDS Alliance, which now provides capacity building assistance to local NGOs in 18 countries (up from 14 in 2000) and has provided skill building to over 3,000 individual NGO staff. Committed to expanding the participation of NGOs in all aspects of HIV/AIDS programs, in 2001 the Office developed an additional mechanism, the REACH project, to support NGO grants worldwide.

- Last year saw a jump in condom social marketing activities as the AIDSMARK project sold 212 million male condoms through social marketing in 20 countries (up from 66 million condoms in 12 countries in 2000).

- IMPACT developed a variety of tools to assist country programs to expand into new areas and to scale up their programs. These include tools for voluntary counseling and testing, for assessing readiness to implement MTCT interventions, and for psychosocial support for orphans and vulnerable children. In addition, IMPACT developed and field-tested a strategic framework for an expanded comprehensive response which will help missions and governments plan program expansion. The governments of Kenya and Nigeria have already adopted this approach.

The Office continually needs to deal with an epidemic that has been far more devastating than anyone anticipated. OHA has needed to balance the continuing importance of prevention with the need to

advance our work in care, treatment and support including preventing MTCT. Recognizing the importance of USAID's response to the epidemic, under the Agency's reorganization, it was decided to upgrade the HIV/AIDS Division to an office. However, the additional staff that is needed has not yet come on board. In any case, the time-consuming reorganization process has been an additional challenge for the Office. At the Administrator's request, in order to allocate USAID HIV/AIDS resources more effectively, the Office took the lead in developing a new operational plan and vetting it with the regional bureaus.

An estimated 40 million people are living with HIV/AIDS today – about 95% of them in the developing world. More than 13 million children under 15 have lost their mother or both parents due to AIDS. In 2000 alone, three million people, including 500,000 children, died of AIDS. Another 5.3 million – including 600,000 children – were newly infected. This translates to one person every six seconds. By the end of the decade, another 40 million people may be infected. Girls and women are particularly vulnerable: nearly half of all infections and in Africa, more than half are in women. Often, they lack control over the risk of contracting HIV for cultural and economic reasons, and they risk passing the infection on to their infants. In Africa, half of new infections are in the 15-24 age group, with young girls and women accounting for 75% of these. To address this problem, USAID HIV/AIDS programs attempt to reach the most vulnerable groups, e.g., women and youth. Last year, USAID developed a new youth-oriented project, YouthNet, that has HIV/AIDS as its most important focus.

Performance considerations and opportunities to have stronger impact on the epidemic were key to the new strategic resource allocation plan that OHA developed, and these were reflected in proposed FY 2002 and FY 2003 budgets and then vetted with the regional bureaus. As a result, USAID's program resources will be focused on field programs where our assistance can save the most lives. Resources for field programs will increase from $192 million, or 61% of the Agency's budget last year, to $389 million, or 78% of our budget next year. So not only will we have more money to spend on prevention, care and children's programs, but more of the money will be spent directly on them.

During FY 2001, USAID met its targets for SO4. While HIV/AIDS prevalence rates continued to rise in FY01 in most regions of the developing world, USAID and other donors contributed to keeping HIV prevalence rates low (less that 2%) in Senegal, Philippines and Indonesia and also reversing the epidemic in several higher prevalence countries such as Uganda, Dominican Republic, Thailand, Zambia and Cambodia.

National surveys conducted over the last three years will be used as baselines for measuring changes in high risk sexual behaviors under USAID's Expanded Response to HIV/AIDS over the next several years. The results from these surveys indicated that condom use with the last "non-regular" sex partners ranged from 5% (Cameroon) to 59% (Uganda) among men and from 1% (Cote d'Ivoire) to 42% (Burkina Faso) among women.

USAID increased the number of countries with condom social marketing programs from 18 in 2000 to 24 countries in 2001. Total condom sales increased from 66 million to 212 million – an increase of 321%. The new countries in 2001 included Madagascar, Mozambique, Lesotho, Namibia and India. In 2000, USAID also supported seven social marketing programs providing female condoms. Total sales for that year were 902,072. In 2001, USAID sold a total of 1,179,878 female condoms through six social marketing programs – in Brazil, Haiti, South Africa, Togo Zimbabwe and Zambia.

Under the Expanded Response in FY 2002, USAID will continue its broad-based central program of leadership, technical assistance, training, research and monitoring to strengthen the capacity of developing and transitional countries to prevent the further spread of HIV infection and to provide services to those infected and others affected by the epidemic. Under the FY 2002 Expanded Response strategy, USAID will focus most of its resources on 23 priority countries and several regional programs around the world.

USAID will also provide ongoing support to UNAIDS and other international partnerships such as IAVI to fulfill its role to coordinate the international community at the global and country levels. For example, USAID is working with UNAIDS to identify a standard set of indicators and targets to measure progress

toward the goals set forth in the U.N. General Assembly Special Session (UNGASS) Declaration of Commitment (against HIV/AIDS). The first report on UNGASS progress is due in 2003.

**SO5 – Increased use of effective interventions to reduce the threat of infectious diseases of major public health importance**

SO5 focuses primarily on the technical areas of Malaria, Tuberculosis (TB), Antimicrobial Resistance (AMR), and Disease Surveillance. In the past year, SO5 has seen several achievements that contribute to developing and introducing new drug regimens, treatment protocols and diagnostic tools; developing and expanding models or best practices; and strengthening health worker capacity to better diagnose and treat patients.

In FY 2001, SO5 continued to support the World Health Organization's (WHO) Roll Back Malaria Initiative (RBM) including working with them to ensure that the "best practices" arising from the Africa Integrated Malaria Initiative guide strategic and technical approaches of RBM and to building consensus with the Reproductive Health/Making Pregnancies Safer to promote preventive malaria therapy for pregnant women through antenatal care clinics. One aspect of the malaria program was momentarily setback, when the lead commercial partner that manufactures insecticides and nets withdrew, however new partnership agreements were signed with six international and African based manufactures to build demand, access, and ensure appropriate use of low cost insecticides and nets in Zambia, Nigeria, Senegal and Ghana. The launch occurred in Zambia in November 2001 and by the end of December more than 100,000 net and insecticide kits had been sold. The existence of high taxes and tariffs delayed implementation in Ghana and Senegal, but recent meetings that included the Government of Senegal, IMF, World Bank, and the commercial partners resulted in the government's commitment to significantly reduce both taxes and tariffs on nets and insecticides. Lastly SO5 is supporting trials designed to evaluate new drug combinations to slow down the rate of drug resistance malaria.

The Tuberculosis program continued to provide financial and technical assistance to WHO's STOP TB Initiative, the Global Drug Facility, and support the Global TB Implementation Plan. TB activities have expanded into 11 new countries over the past year with ongoing efforts supporting Regional Bureaus and Missions in strengthening National TB Programs to comply with and expand the DOTS protocol in a total of 35 countries. A major challenge confront the expansion of the DOTS protocol is the limited availability of technical expertise and their capacity to absorb resources. In order to address this challenge the TB program is developing the capacity of National TB Program staff in countries as well as a cadre of international consultants. In the past year, training courses to develop consultants were conduct in five countries, and a Task Force on Training is developing a strategy for country capacity building along with an inventory of courses, training materials, and consultants. Additionally, regional TB Management Training Courses were conducted in Tanzania, Nicaragua, Benin, and Vietnam. USAID has provided much needed assistance in revising and conducting courses in TB drug management as part of the TB Management Training Course and has offered a TB drug procurement regional course in Africa and Vietnam for untrained participants who had recently been given the responsibility for drug procurement. Consecutively a new a model for electronic registry of TB has been successfully piloted in Botswana and the Southern African region, and investments in diagnostics have lead to the development of a simple serodiagnostic test for the rapid diagnosis of TB, which is planned for field trials in 2002.

In that past year, SO5 has been a major contributor in developing technical materials and advocating the importance of AMR by supporting the development of The WHO Global Strategy for the Containment of Antimicrobial Resistance, which was released in September 2001, and is a key document to be used in the development of USAID Mission AMR country plans. However it is going to be a challenge to operationalize this strategy in cost-effective interventions, which will be a key focus in FY 2002. Capacity building is being addressed in the Drug and Therapeutic Committee Training Course, which reached 171 individuals in 42 countries and has linked participants through a website to ongoing technical assistance. USAID is supporting a regional effort to establish a Malaria AMR surveillance system in South America, building on the WHO multi-country network recently established in Southeast Asia. Currently studies are underway to identity better diagnostic and treatment protocols to reduce AMR in pneumonia.

The last component of the SO5 program focuses on infectious disease surveillance. Efforts to improve surveillance in the past year have focused heavily on strengthening epidemiology capacity globally by supporting the Training Programs in Epidemiology and Public Health Interventions NETwork (TEPHINET). Country specific investments have resulted in applied epidemiology training for 55 district level epidemiologist in Uganda and Zimbabwe. Efforts to strengthen national disease surveillance programs in the Africa Region are under way in four African countries as part of the larger African Integrated Disease Surveillance and Response Initiative. In the Europe and Eurasia region SO5 is supporting a multi-partner regional initiative, which will expand a health information system model for vaccine preventable diseases that was developed in Ukraine.

A heavy focus of SO5 is to improve the quality of preventive and curative care that the public receives. As a result, the initial beneficiaries in many of these programs include the World Health Organization, Ministries of Health, physicians, nurses, outreach workers, epidemiologists, pharmacists, universities and research institutes. However, these investments are made with the knowledge that the ultimate beneficiaries are men, women and children who will receive appropriate care or are prevented from acquiring an infectious disease. Strengthening TB programs has resulted in improved treatment as in Rio de Janeiro where treatment success rates increased to 84% and in Kazakhstan where improvements in the National TB Program has resulted in a 15% decline in TB mortality. In the case of malaria, the availability of anti-malarial drugs to pregnant women in Malawi has resulted in a 9% decline in low birth weight babies and the increased availability of inexpensive and effective preventive tools such as bednets and insecticides is preventing new cases of malaria. SO5 met its targets for the reporting period.

**Annual Report Part IV: FY 2001 Performance Data Tables and Results Framework**

The Bureau provided input for the Agency's Annual Performance Report, Performance Targets for all five GH SOs, which were rated as "met."

**VII. Environmental Compliance.** The Global Health program qualifies for a Categorical Exclusion pursuant to 22 CFR 216.2(c)(2)(viii), which states that "Programs involving nutrition, health care or population and family planning services, except to the extent designed to include activities directly affecting the environment (such as construction of facilities, water supply systems, waste water treatment, etc.)" generally do not require an Initial Environmental Examination, Environmental Assessment and Environmental Impact Statement.

During the design stage of Activity Approval Documents (AAD), each SO/AAD Team analyzes the impact of the proposed activities on the environment and monitors them to ensure compliance with the criteria for a Categorical Exclusion. An Environmental Determination signed by the Bureau Environmental Officer is included with each Activity Approval Document approval. In addition to this initial approval, a determination is made regarding the need for any subsequent approval of activities under individual awards. Approval is also requested on a case by case basis when circumstances warrant. For example, the HIV/AIDS Prevention and Control Program's Initial Environmental Examination approved by the Global Bureau Environmental Officer on September 25, 1997, was again reviewed in FY 2000 and FY 2002 because of the addition of insecticide treated bed nets (ITNs) to country activities under the AIDSMark cooperative agreement. An IEE analysis suggested that the use of insecticides for the treatment and re-treatment of bed nets would result in only a modest potential for undesirable environment and human health impacts. Little, however, is known about the country specific interventions under AIDSMark. Each separate country program may choose a different approach, product or supply. Prior to distribution of any insecticides, it was agreed that AIDSMark would prepare a Pesticide Evaluation Report and Safe Use Action Plan (PERSUAP) for each country program that extends into the marketing of ITNs. The PERSUAP examines the packaging and labeling of insecticides as proposed in that country, and a detailed action plan for ensuring safe handling and disposal of all insecticides and their monitoring is developed. The Bureau Environmental Officer has cleared this approach.

The Bureau for Global Health is in the process of designing the following new AAD. Approval is planned for August 2002 for the Child Health Research AAD. The purpose of the activities under the AAD is to conduct applied research identify and evaluate new technologies, and assess the effectiveness and impact of child health interventions relating to anti-microbial resistance, diarrheal diseases, acute respiratory infections, tuberculosis, malaria and malnutrition. Approval of the Bureau Environmental Officer will be requested prior to final approval.

One additional AAD, Communication, was approved in December 2001. The purpose of the AAD is to employ communication effectively for improving health, stabilizing population and advancing a health competent society.